ANTHRAX CASE INVESTIGATION - Page 1 of 3

Indiana State Department of Health
State Form 51641 (7-04)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✱
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ Employer ○ School ○ Day Care

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Type of Infection:
- ○ Cutaneous
- ○ Gastrointestinal
- ○ Inhalation

Diagnostic tests:
- ○ Chest x-ray, Positive
- ○ Chest x-ray, Negative

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Source of Positive Specimen:
- ○ Lesion Swab
- ○ Skin Biopsy
- ○ Stool
- ○ Blood
- ○ Sputum
- ○ CSF
- ○ Other, specify:

Please return completed form within one business day to:

Indiana State Department of Health
Attn: Epidemiology Resource Center
2 North Meridian Street
Indianapolis, IN 46204
FAX: 317-234-2812

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

Physician/Hospital Phone - -

Was the patient treated with antibiotics for this illness?

○ Yes ○ No

If Yes, antibiotic:

Start date: / /

Was the patient hospitalized?

○ Yes ○ No

If Yes, admission date: / /

Discharge date: / /

Hospital:

Did patient die?

○ Yes ○ No

Section 3. Risk Factors

Date of possible exposure / /

Location(s), be as specific as possible

How was person exposed (check all that apply)?

○ Letter ○ Powder ○ Other (see below)
○ Package ○ Sick Animal ○ Unknown

If letter or package: ○ Closed ○ Opened

If Powder, describe

If Other, describe

Was there any prior threat of attack?

○ Yes ○ No

If Yes, describe

Were law enforcement authorities notified (only in the event of a suspicious exposure)?

○ Yes ○ No

If Yes, which branch:

○ Local Police ○ Local Sheriff ○ State Police ○ FBI ○ Other, specify:

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Section 3. Risk Factors (continued)

Has suspicious material been confiscated?

○ Yes ○ No

If Yes, by whom

Location of materials

Did an official responder assess scene of exposure for credible threat?

○ Yes ○ No

If Yes, which agency:

○ Fire ○ Police ○ Sheriff ○ Hazmat ○ State Police ○ FBI ○ Other, specify:

Was decontamination performed?

○ Yes ○ No

If Yes, type:

○ Clothing Removal ○ Hand Washing ○ Shower/Shampoo ○ Environmental Cleaning

Has suspicious item/environmental sample been sent for testing?

○ Yes ○ No

If Yes, submitter

Laboratory

__ / __ / __ **Results:** ○ Positive ○ Negative

Date Sent

Is this patient related to a confirmed exposure site?

○ Yes ○ No

__ / __ / __

If Yes, date

Where

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

___ - ___ - ____ __ / __ / __

Phone Number **Date**